

HOSPICE SERVICES PAYMENT SYSTEM

payment**basics**

Revised:
October 2016

The Medicare hospice benefit covers a broad set of palliative services for beneficiaries who have a life expectancy of six months or less, as determined by their physician. Beneficiaries who elect the Medicare hospice benefit agree to forgo curative treatment for their terminal condition. For conditions unrelated to their terminal illness, Medicare continues to cover items and services outside of hospice. Typically, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities and other inpatient settings. Hospice providers can be freestanding entities or based in hospitals, skilled nursing facilities, or home health agencies.

CMS data show rapid growth in use of the hospice benefit among Medicare beneficiaries and associated program spending. The number of beneficiaries using hospice more than doubled between 2000 and 2014, exceeding 1.3 million in 2014. The total number of providers has also increased. The number of hospice agencies participating in the Medicare program increased by 81 percent from 2000 to 2014. In addition, as of 2014, about 63 percent of hospice agencies were for profit, compared to about 30 percent in 2000. Medicare payment for hospice grew from almost \$3 billion in 2000 to \$15.1 billion in 2014.

The hospice benefit and Medicare payment

The hospice benefit is designed to provide pain relief, comfort, and emotional and spiritual support to patients with a terminal diagnosis. To provide this type of care, the benefit covers an array of services, such as:

- skilled nursing services;
- drugs and biologicals for pain control and symptom management;
- physical, occupational, and speech therapy;

- counseling (dietary, spiritual, family bereavement, and other counseling services);
- home health aide and homemaker services;
- short-term inpatient care;
- inpatient respite care; and
- other services necessary for the palliation and management of the terminal illness.

Setting the payment rates

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit (Figure 1). Medicare makes a daily payment, regardless of the amount of services provided on a given day and on days when no services are provided. The daily payment rates are intended to cover costs that hospices incur in furnishing services identified in patients' care plans. Payments are made according to a fee schedule that has four different levels of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC) (Table 1).

The payment rates are updated annually based on the hospital market basket index, which beginning in fiscal year 2013 is reduced by a productivity adjustment (as required by the Patient Protection and Affordable Care Act of 2010). An additional reduction to the market basket update of 0.3 percentage points was required in 2013 through 2017 and possibly in the years 2018 and 2019 if certain targets for health insurance coverage among the working age population are met. Payments to hospices that do not report specified quality data are reduced by 2 percentage points beginning in fiscal year 2014.

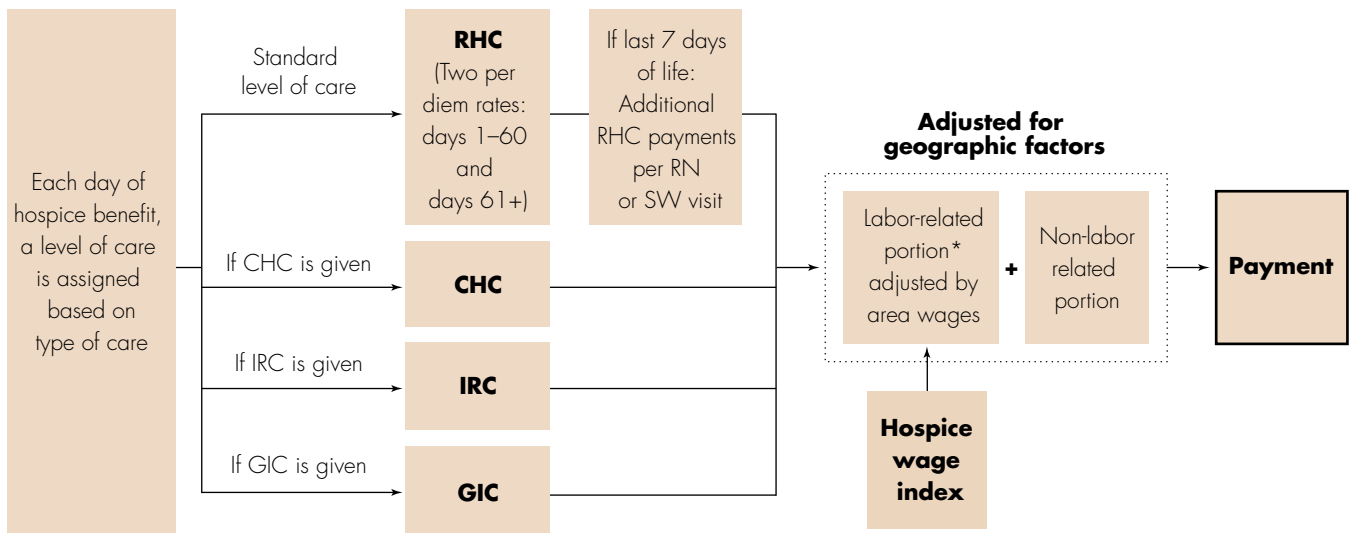
The four levels of care are distinguished by the location and intensity of the services provided. RHC is the most common level

*This document does not
reflect proposed legislation
or regulatory actions.*

MEDPAC

425 I Street, NW
Suite 701
Washington, DC 20001
ph: 202-220-3700
fax: 202-220-3759
www.medpac.gov

Figure 1 Hospice prospective payment system



Note: RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care), RN (registered nurse), SW (social worker).
 *The labor-related portion adjusted by the wage index varies, depending on level of care (see Table 1). Wage index adjustment is based on the location of the patient, not the hospice agency.

of hospice care, accounting for more than 95 percent of all hospice days. Other levels of care—GIC, CHC, and IRC—are available to manage needs in certain situations. GIC is provided in a facility on a short-term basis to manage symptoms that cannot be managed in another setting. CHC is

intended to manage a short-term symptom crisis in the home and involves eight or more hours of care per day, mostly nursing. IRC is care in a facility for up to five days to provide an informal caregiver a break. Unless a hospice provides CHC, IRC, or GIC on any given day, it is paid at the RHC

Table 1 Hospice levels of care and rates

Level of care	Description	Base payment rate, FY 2017	Labor-related portion of payment adjusted by the wage index, FY 2017
RHC	Home care provided on a typical day: Days 1–60	\$191	69%
	Home care provided on a typical day: Days 61+	150	69
CHC	Home care provided during periods of patient crisis	965	69
IRC	Inpatient care for a short period to provide respite for primary caregiver	171	54
GIC	Inpatient care to treat symptoms that cannot be managed in another setting	734	64

Note: FY (fiscal year), RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care). Payment for CHC is an hourly rate (\$40.19 per hour, with maximum payment per day equal to about \$965) for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. In addition, a nurse must deliver half of the hours of this care to qualify for CHC-level payment. The above rates apply to hospices that submit the required quality data. The rates are 2 percentage points lower for hospices that do not submit the required quality data.

Source: CMS Manual System Pub 100–04 Medicare Claims Processing, Transmittal 3559, “Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2017.” July 8, 2016.

rate. For any given patient, the type of care can vary throughout the hospice stay as the patient's needs change.

Historically, each level of care has been associated with its own base payment rate. The different base rates reflect variation in expected input costs across the levels of care.

Prior to January 2016, Medicare had a single base rate for each RHC day in an episode. Beginning January 1, 2016, Medicare changed how it pays for RHC. There are now two RHC base payment rates: a higher rate for days 1 to 60 and a lower rate for days 61 and beyond. In addition, Medicare makes additional RHC payments for registered nurse and social worker visits that are provided during the last seven days of life.

These changes to the structure of RHC payments were the first changes to the hospice payment system since its inception in 1983. The new RHC payment structure is intended to better align payments with the costs of providing hospice care throughout an episode. Hospices tend to provide more services at the beginning and end of an episode and less in the middle. The new payment structure better matches that pattern of care than a single RHC base rate.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each level of care has a labor share and a non-labor share; those amounts differ across each level of care, reflecting the estimated proportion of input costs that is attributable to wage and non-wage costs. The labor share of the base payment amount is adjusted by the hospice wage index for the location in which care is furnished and the result is added to the non-labor portion.

From 1983 to 1997, Medicare adjusted hospice payments using a 1983 wage index, based on 1981 Bureau of Labor Statistics data. In fiscal year 1998, after a negotiated rulemaking process, CMS began using the most current hospital wage index to adjust hospice payments, and applied a budget

neutrality adjustment each year to make aggregate payments equivalent to what they would have been under the 1983 wage index. This budget neutrality adjustment increased Medicare payments to hospices by about 4 percent. In fiscal year 2010, CMS began phasing out the budget neutrality adjustment over seven years, reducing it by 0.4 percentage points in 2010 and by an additional 0.6 percentage points each subsequent year until it was eliminated entirely in 2016.

Two caps limit the amount and cost of care that any individual hospice agency provides in a single year. One cap limits the number of days of inpatient care an agency may provide to not more than 20 percent of its total patient care days. The other cap is an absolute dollar limit on the average annual payment per beneficiary a hospice can receive. If a hospice's total payments exceed its total number of Medicare patients multiplied by \$28,404.99 in the year ending September 30, 2017, it must repay the difference. Unlike the daily rates, this cap is not adjusted for geographic differences in costs. The hospice cap is adjusted annually by the medical expenditure category of the consumer price index for all urban consumers.

Beneficiary liability for hospice services is minimal. Hospices may charge a 5 percent coinsurance for each drug furnished outside of the inpatient setting, but the coinsurance may not exceed \$5 per drug. For inpatient respite care, beneficiaries are liable for 5 percent of Medicare's respite care payment per day. Beneficiary coinsurance for respite care may not exceed the Part A inpatient hospital deductible, which was \$1,288 in 2016. ■